Center for Health Care Strategies

Center for the Urban Child and Healthy Family at Boston Medical Center:

A New Pediatric Care Model to Help Children and Families Thrive

As the largest safety net hospital in New England, Boston Medical Center (BMC) has long been known for its innovative approaches to improve the health of its patients, many of whom have social and economic needs that affect their well-being.

AT-A-GLANCE

Organization: Center for the Urban Child and Healthy Family, Boston Medical Center

Goal: Create the *Pediatric Practice of the Future* care model

Population: Children ages 0-5 and their families

Featured Services: Integrated physical and behavioral health care for the family, support for health-related social needs, promotion of social-emotional health

Historically, pediatric primary care has been structured to focus predominantly on physical health, with the timing of visits scheduled around the standard childhood immunization schedule rather than on a more holistic view of each child's physical, emotional, and social development. This model has left many children and families without needed care and supports, especially families facing poverty, racism, housing instability, and other adversities. Some innovative models and practices have emerged for more holistic care in recent years, though these models often have not been developed in partnership with families and are not widespread.

"Pediatrics has tinkered around the edges, but it hasn't really fundamentally overhauled our care delivery model. The family voice often has been missing from prior conversations about primary care innovation," says Megan Bair-Merritt, MD, MSCE, executive director of the Center for the Urban Child and Healthy Family (the Center), which was launched at BMC in 2016 to support clinical innovations in pediatric care.

COMPLEX CARE INNOVATION IN ACTION

This profile is part of an ongoing series from the Center for Health Care Strategies (CHCS) exploring strategies for enhancing care for individuals with complex health and social needs within a diverse range of delivery system, payment, and geographic environments. **LEARN MORE »**

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To improve health care delivery for children and families, the Center developed a new care model, the *Pediatric Practice of the Future* (POF), based on the self-identified needs and priorities of families. This universal care practice model provides integrated physical and behavioral health care to families and empowers them to say what is important for their child and family's health goals, enabling them to drive their health care priorities.

A POF pilot program of 100 families with at least one child under three years old is in its second year. Most of the families are insured by Medicaid. POF provides care through integrated, multidisciplinary teams that work to reduce the systems-level fragmentation that often confounds families' health care experiences. The multidisciplinary team works to strengthen the social-emotional health and financial mobility of children and families and engage in community partnerships to address social determinants of health. The goal is to improve care for families with young children and create a scalable, sustainable model so children can be healthy and meet milestones to be ready for school by age five.

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Megan Bair-Merritt, MD, MSCE, Executive Director, Center for the Urban Child and Healthy Family

BMC is a part of the Center for Health Care Strategies' *Advancing Integrated Models* (AIM) initiative, supported by the Robert Wood Johnson Foundation. Through this work, the pilot is collecting data to understand how its program components are working and determine which elements can be scaled for use in larger practices, such as BMC's 14,000-patient pediatric primary care clinic. AIM is also working with BMC and the pilot's payer, BMC HealthNet Plan, on alternative funding approaches and other ways to make the model sustainable. The POF pilot is supported by the Pincus Family Foundation, The JPB Foundation, and private philanthropic support.

Equity by Design

From the start, achieving health equity for patients and families has been part of the program's foundation. BMC conducted a year-long human-centered design process for the pilot in partnership with a Boston-based firm, Agncy, that specializes in using design to reduce structural inequities. The collaborative group spent time in the BMC pediatric clinic observing families' experiences of care as well as talking with families in their homes about what they want their health care to be. The design team also spoke with clinic providers, administrators, and frontline staff.

Themes emerged from those conversations that identified what would become key program elements. “The pilot is a response to what we learned from this human-centered design process,” says Carey Howard, MPH, the Center’s program director. Because of that work, the program is holistic and family-driven, builds on families’ strengths over time, and delivers care that is intentional and responsive rather than episodic and reactive.

The POF pilot launched in January 2020, yet the team continues to employ human-centered design methods to garner ongoing feedback from participating families, Howard notes. This is accomplished both informally, through the care team routinely asking families what they think about elements of the POF model as they are experiencing it, and more systematically through surveys that ask families to tell the team about their experiences and perceptions of care within POF. This input is used for rethinking and adapting how the care model is organized and delivered.

Key Elements of the Model

Pediatric Practice of the Future Innovation Teams

Two POF innovation teams support families. Team members include two pediatricians, two community wellness advocates (CWAs), a social worker, a nurse, a financial coach, and two practice coordinators. “We collaborate to deliver the best care,” says Mitsouka Exantus, a CWA in the pilot. Team members talk with families about their preferences and concerns, sharing that information with others on the team. In that way, Exantus says, “we ensure we’re constantly being reminded of what families are voicing as priorities to them, not what we think they need.”

She describes her CWA role as providing a multidirectional bridge connecting patients and families to providers, the health care system, and community resources. Because families and CWAs have frequent contact with each other, they often build close bonds. “The first thing they take out of their relationship with us is having somebody they can trust listening to them, somebody who’s actually paying attention,” Exantus says.

We’re constantly being reminded of what families are voicing as priorities to them, not what we think they need.

Mitsouka Exantus, Community Wellness Advocate,
Center for the Urban Child and Healthy Family

Families call CWAs for help in navigating vital support outside of well-child visits, in areas that affect the child’s and family’s overall health as well as specific needs. That assistance might be for finding food and housing resources, SNAP benefits, translation services, or getting a child’s medical records for school. Parents have told Exantus how

much their lives have improved by, for example, having a reliable source of diapers and diapering supplies through the program. The CWAs and financial coach also help families find programs to reduce bills, apply for jobs, or get other economic help.

Family Eco-Mapping

When families first enter the pilot, they meet with a team social worker or CWA for family eco-mapping. Through that process, they define their family, then talk about their other important personal and community relationships, including wider circles of family, friends, medical or other providers, and organizations such as faith and social groups. Eco-mapping helps define how the family perceives their strengths and where barriers exist, so they can prioritize their needs. The process also establishes a connection with the social worker or CWA, gives the innovation team insight about the family's world, and begins identifying areas in which to set family-directed goals and shape a care plan. Howard says in addition to CWAs and social workers, nurses are being trained to do the eco-mapping as well.

Pre-Visit Planning

Pre-visit planning is held before each pediatric well-visit. The CWA reaches out to talk with the family by phone or in person (planned for post-COVID times) about concerns they want to address during the visit. This lets the family determine the agenda and discuss services needed without the pressure of being in a fast-paced clinic appointment.

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Mother participating in the *Pediatric Practice of the Future* pilot

At a weekly meeting, POF innovation team members review what families coming that week want to discuss and prepare a visit agenda to use during each family's visit. On the appointment day, the family and provider confer to see if the family's priorities for the visit have changed. After the visit, the team follows up to make sure families have connections to support resources.

One mother in the pilot, who has an eight-month-old baby and 10-year-old child, appreciates the pre-visit planning. "They spend time with you on the phone and you tell them about what's going on with the child," she says. "When you get there [the clinic], the doctor knows everything. I love that. Because sometimes when you leave a doctor's office, you forgot something. With the pre-visit planning, you're at home, you're calm. You remember things you want the doctor to know."

Family Goal Setting and Wellness Planning

The POF team also helps with family goal setting and wellness planning, another family-centered feature. This process enables families to set goals for their child's development and well-being that can be achieved by establishing clear steps, building timelines, identifying possible supports or barriers, and having resources for help. The team hopes to reorient the primary care experience to be driven by and responsive to the family's needs instead of clinician-relevant objectives. The innovation team has found that because this is often a new approach to health care, some families express hesitation about setting goals initially. It was important for the team to reinforce that, "we're committed to standing by their side and partnering with them where they are at that moment," says Bair-Merritt.

Trauma-Informed Care, Anti-Racism, Bias, and Equity Trainings

To better serve families and providers in a practice model that upends historic hierarchical medical and social systems, the pilot incorporated team training on trauma-informed care, anti-racism, implicit bias, and racial equity. The 12-hour baseline trainings were given to all team members to promote the value of all voices and roles on the care teams as well as strengthen relationships with families. POF partnered with a local public health agency for the trainings, which continue to be held regularly to address issues that arise.

Community- and Faith-Based Organization Partnerships

Partnerships with child- and family-serving organizations and faith-based communities are also essential for the pilot, for POF's future growth, and for achieving program goals. According to Howard, the COVID-19 pandemic limited in-person interactions with partners, so some of these relationships haven't developed as much as planners originally had hoped. POF intends to pursue more partnerships based on families' suggestions of groups that are central to their well-being, such as churches with health initiatives or community organizations that connect families with their cultural heritage or language.

Long-Term Implementation

There's nothing easy about establishing a new pediatric care model, even as a pilot. Challenges for POF range from altering long-established roles for providers and families to rethinking what data should be gathered for outcomes assessments to funding a format that doesn't fit typical insurance reimbursement guidelines.

"Often in pediatrics, children are healthy," Howard says. "There's not a lot of incentive to invest in health promotion to help children grow into healthy adults."

Such projects tend to seek sustainability through funding from grants or philanthropy — money that may be reduced or disappear entirely in subsequent years. Reforms in the current payment system, including Medicaid, are needed to support the scale and spread of the POF care model.

POF is looking to bring insurers on board by measuring the impacts of the model on long-term outcomes for family health and child health, such as being ready to start kindergarten by age 5. That differs greatly from traditional Medicaid quality metrics, such as having immunizations on schedule, which focus on system performance.

To accomplish such a change means using new metrics to identify quality pediatric care, then collecting and using data to show evidence of quality improvement, beneficial outcomes, and affordability. The POF pilot showed some of that data to its payer health plan, Howard says, resulting in a partnership for an upfront infrastructure payment. That support covered costs for team members such as CWAs, whose services usually are not covered by health insurance. Data will continue to be collected to refine and scale facets of the program and drive decisions about implementing the new care model.

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Carey Howard, MPH, Program Director,
Center for the Urban Child and Healthy Family

BMC is conducting an IRB-approved study as part of the pilot to gauge the effectiveness of program components on family health outcomes. For this research, POF is using new benchmarks through quality metrics that better relate to child and family well-being. The program has proposed to its payer partner that in addition to standard pediatric measures, the following metrics be used as process and outcome measures:

- **Dyadic (parent and child) health care participation** by evidence of a primary care provider for each and completed appointments;
- **Health equity/parental trust in health care** demonstrated by responses to an annual questionnaire, with parental trust increasing to reach yearly benchmarks;
- **Economic well-being**, determined through annual screenings of financial health and referrals to services for those in need; and
- **School readiness**, drawn from annual assessments of school readiness for children ages three- to five-years-old.

Findings and Outcomes

The POF pilot collects a wide range of information from the electronic medical record and from surveying families directly, monitors the care delivery process, and tracks results. Results demonstrate high rates of well-child visit attendance, referral completion, and receipt of vaccinations, including influenza.

Program findings highlight the role of CWAs in promoting connections with families and building trust in the care received. "CWAs are responsible for the majority of those interactions," Howard says. "Families feel supported by having that additional person."

More than half of families in the pilot have met with the program's financial coach. Most of those sessions were held by phone. Families discussed goals such as budgeting, savings, building credit, reducing debt and expenses, and employment or career support.

POF's focus on social and emotional support, followed by clinical care, appears to strengthen parents' trust in providers and perceived health equity in the services they receive. A questionnaire administered between December 2020 and February 2021 to about half of participating families showed nearly 94 percent strongly agreed or agreed with these statements: "*Members of my care team know what's on my care plan, including the things that are important to me*," and "*I believe my care team feels comfortable around people who look like me and/or sound like me*."

Community wellness advocates are responsible for the majority of [family] interactions. Families feel supported by having that additional person.

Carey Howard, MPH, Program Director,
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Yet there remain gaps to be addressed. One key limitation to the questionnaire was that only English-speaking families were surveyed, though in future iterations, the team will administer the questionnaire in Spanish and Haitian Creole as well. Even with language in common, 14.3 percent of families strongly agreed or agreed with the statement, "*At times I feel I am treated differently here based on my race, ethnicity and/or gender identity*."

In early 2022, the POF team will hold a family forum to share results from the questionnaire and continue to garner input and guidance on program improvements that would feel most impactful to families. Additionally, the questionnaire will be administered annually to POF families to track responses over time.

Challenges and Lessons

The pilot launched in January 2020 and the COVID pandemic caused some enrollment delays. It took until March 2021 to reach their goal of enrolling 100 families. The pandemic also affected the plan to have CWAs visit families in their homes for services. Face-to-face meetings outside of the clinic were replaced by phone calls, Zoom calls, and texting.

The success of remote connections surprised some team members. "Before COVID, I would have said nothing could compare to home visits," says CWA Exantus. "Now, after experiencing life in a pandemic, the way we do things has changed so much. It's a matter of assessing what each family prefers." When in-person contact begins again, some families might choose it while others opt to remain remote, she says, because they don't want someone in their home or they want flexibility while communicating.

COVID prevented group outreach sessions. These events were envisioned to bring POF families together for meetings on topics such as breastfeeding and to form support systems with each other. The pandemic also shifted families' discussions with the financial coach away from planning for an economically more secure future. Instead, parents and caretakers were more likely to ask for help with immediate needs for food, housing, and jobs.

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Mitsouka Exantus, Community Wellness Advocate, Center for the Urban Child and Healthy Family

The pandemic also delayed administration of the IRB-approved outcomes evaluation for the pilot. POF staff also had to balance plans for innovations within the limitations of a strained health care system. With COVID concerns ongoing, the program continues to be flexible as it delivers care and assesses data.

Other valuable lessons emerged during the pilot. POF aims to strengthen parent/caregiver health along with child health, but some families were only interested in pediatric services. The adults in those families didn't want to talk about their health needs or extend clinic appointments to receive care themselves.

Long-term goal setting was hard to accomplish. Many families said they want help with setting and achieving goals, but their acute needs made setting goals difficult. "None of us could engage in long-term goal setting if we're worried about being imminently evicted from our homes," Bair-Merritt says, noting that families have been failed before by systems or well-intentioned people. POF is reframing the concept of goal setting to better assist families in their efforts.

Drawing from experiences in the pilot, POF planners have additional advice for others interested in starting a similar program:

- **Take meaningful action** to include team members and families in implementing the project. Their input produces more creative ideas.
- **Cross-train clinical team members** in model features to promote scalability.
- **Invest in robust data capacity** by allotting sufficient time and attention to create strong systems for data gathering and use.
- **Prioritize approaching key stakeholders early** and find metrics that interest them. This can help the work continue.

Next Steps

As the POF pilot moves forward, it expects to build the capacity of CWAs to provide economic mobility support. Plans are also forming to gradually expand program elements into the larger BMC pediatric primary care clinic.

The pilot's IRB-approved study is gathering more data. Research efforts continue to measure the program's impact. The ongoing partnership with BMC HealthNet Plan will be reviewing data and considering alternative payment models.

In fall 2021, in partnership with the Institute for Healthcare Improvement, the Center launched a national year-long learning and action network of four community health centers and five hospitals to conduct a deep feasibility analysis of the POF model. This work will inform the feasibility of scale and spread of the POF model to other contexts. This wider application of the new pediatric care model could provide insights on how to achieve success in varied settings. It also will improve the approaches being used in the pilot.

"We're learning and changing all the time," Bair-Merritt says.

Author Robin Warshaw is an award-winning writer who focuses on medicine, social issues, and health care.

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The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.